MaineCare Services
An Office of the
Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

MaineCare's Accountable Communities Initiative

June 2015

Maine's Accountable Communities (ACs): Our Definition

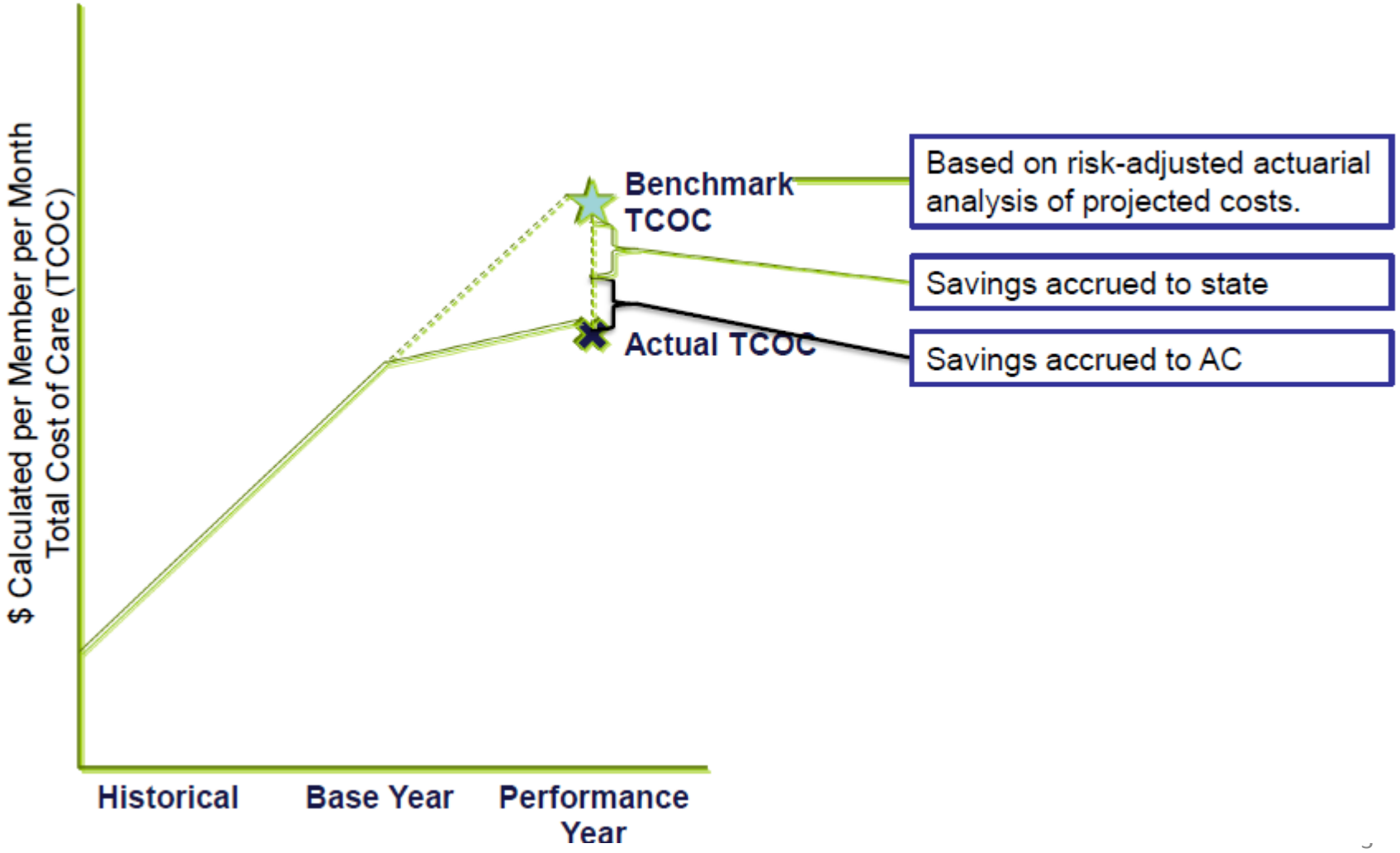
An entity responsible for population's health and health care costs that:

- Is provider-owned and driven
- Is characterized by community collaboration and a strong consumer component
- Includes shared accountability for both cost and quality

In traditional managed care, a managed care organization is responsible for care and cost that is delivered through providers

Accountable Communities

Shared Savings/ Losses Models



Accountable Communities

Shared Savings/ Losses Models

Choice of two models (in both models, Fee for Service continues unchanged):

1. Model I - requires minimum of 1,000 members
   - Share in a maximum of 50% of savings, based on quality performance, with cap at 10% of benchmark TCOC
   - No downside risk in any of the three performance years
2. Model II - requires minimum of 2,000 members
   - Share in a maximum of 60% of savings, based on quality performance, with cap at 15% of benchmark TCOC
   - No downside risk in first performance year
   - Liable for 40-60% of losses, based on quality performance, in years two and three, with cap at 5% of benchmark TCOC in Year 2 and 10% of benchmark TCOC in Year 3

Maine's Accountable Communities: The Basic Components

- Providers work together and may share in any savings achieved
- The amount of shared savings depends on performance on quality measures
- Open to any willing and qualified providers statewide (through application process)
- Possible to have multiple Accountable Communities in one geographical area
- Members retain choice of providers
- Maximize measure alignment with other Accountable Care Organization (ACO) initiatives
- Flexible design encourages innovation

Who Can Be an Accountable Community and What Are the Requirements?

- One or multiple provider organizations represented by a Lead Entity. Lead Entity does not need to be a provider.
- Include providers that directly deliver primary care services and meet Primary Care Case Management requirements.
- Include at least one provider of services under each of the following three categories, if there is such a provider serving members in the AC's Service Area:
  - Chronic Conditions
  - Developmental Disabilities
  - Behavioral Health

Who Can Be an Accountable Community and What Are the Requirements?

Detail for last bullet on previous slide

- **Chronic Conditions**
  - Health Home Practices (HHPs) or Community Care Teams (CCTs),
  - Providers of Targeted Case Management (TCM) services for children with chronic health conditions, or
  - Providers of TCM services for adults with HIV

- **Developmental Disabilities**
  - Providers of TCM for children with developmental disabilities, or
  - Providers of TCM for adults with developmental disabilities

- **Behavioral Health**
  - Behavioral Health Home Organizations
  - Providers of Community Integration
  - Providers of TCM for children with Behavioral Health Disorders, or
  - Providers of TCM for adults with Substance Abuse Disorders

Who Can Be an Accountable Community and What Are the Requirements?

- Have relationships or policies to ensure coordination:
  - with all hospitals in the AC's Service Area
  - with at least one Public Health Entity, if there is such a Public Health Entity that serves members in the AC's Service Area.
- If the AC includes a Health Home Practice, invite the HHP's partner(s) (i.e., CCT and/or Behavioral Health Home Organization) services to participate in the AC.
- Include two MaineCare members in Governance.

What could an Accountable Community look like?

- Federally Qualified Health Center
- Critical Access Hospital
- Home & Community Based Waiver Services Provider

- Pediatrics Practice
- School Health Center
- Dentist Practice

- 2 Health Home practices
- Behavioral Health Home
- Pharmacy

- Single Health System

- Hospital
- 3 Hospital-owned Primary Care Practices
- 2 Nursing Facilities

- 4 Primary Care Practices
- 3 Behavioral Health Organizations

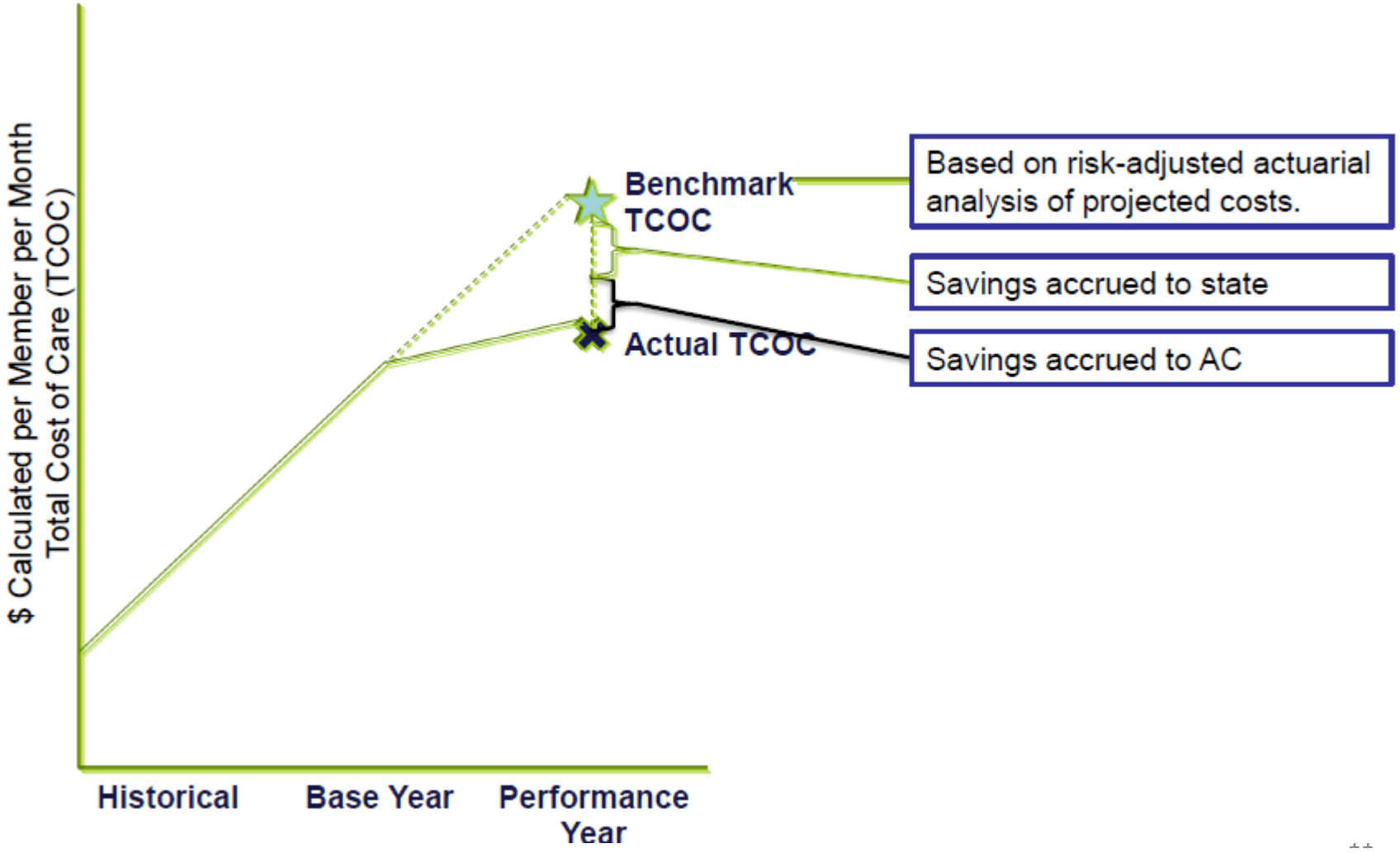
Attribution Methodology

Members with six (6) months continuous eligibility or nine (9) months non-continuous eligibility

1. Members enrolled in a Health Home Practice that is part of an Accountable Community
2. Members not captured in step 1 who have a plurality of primary care visits with a primary care provider that is part of an AC
3. Members not captured in steps 1 or 2 who have three (3) or more ED visits with a hospital that is part of an AC.

Accountable Communities

Shared Savings/ Losses Models



Total Cost of Care (TCOC): Core Services

General Acute Inpatient	Inpatient
Psychiatric Inpatient	Inpatient Psychiatric
General Acute Outpatient	Outpatient
Psychiatric Outpatient	Outpatient Psychiatric
Physician -- Primary Care	Physician, Physician Assistant, Nurse Practitioner, Nurse Midwife, Federally Qualified Health Centers, Rural Health Centers, Indian Health Services
Physician -- Specialty	Physician, Physician Assistant
Mental Health	School Health Centers, Behavioral Health Services, Rehabilitative and Community Support Services
Laboratory/ Radiology	Lab & Imaging Services
Long Term Care	Hospice, Home Health
Durable Medical	Durable Medical Equipment
Other	School Health Centers, Ambulance, Dialysis, Early Intervention, Family Planning, Occupational & Physical and Speech Therapy (including services provided in schools and at Nursing Facilities), Chiropractic Services, Optometry, Audiology, Podiatry
Pharmacy	Pharmacy

Total Cost of Care (TCOC): Optional Services

Adult Family Care Home	Long Term Care Services and Supports*
Assisted Living Services	Long Term Care Services and Supports*
Children's PNMI	Children's PNMI
Day Health	Long Term Care Services and Supports*
Dental	Dental
HCBS Waiver Services	Long Term Care Services and Supports*
ICF-ID	Long Term Care Services and Supports*
Long Term Care	Long Term Care Services and Supports*
Nursing Facility	Long Term Care Services and Supports*
Personal Care	Long Term Care Services and Supports*
Private Duty Nursing -- Adult/Children	Long Term Care Services and Supports*

*excluding Home Health, Hospice, and Physical, Occupational and Speech Therapy provided at Nursing Facilities, which are all core

Data Adjustments

- To calculate benchmark TCOC, baseline year TCOC amount is adjusted for:
  - Policy changes
  - Trend
  - Risk
- To minimize variations from one year to the next due to AC members with large claims, total annual claims for any individual member in excess of the following claims caps will not be included in benchmark or actual TCOC :
  - 1,000-1,999 members: $50,000
  - 2,000-4,999 members: $150,000
  - 5,000+ members: $200,000

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Shared Savings and Loss Details

Minimum savings to qualify for savings/loss payment

AC Lead Entity Member Population Size	Minimum Savings/Loss Rate
1,000 – 4,999	2.5% of Benchmark TCOC
5,000 +	2.0% of Benchmark TCOC

Model I & II Shared Savings Example For Accountable Community ABC

- Benchmark TCOC for Year 1: $500 PMPM
- Actual TCOC for Year 1: $390 PMPM
- Savings = $110 PMPM, exceeds 2% threshold, so AC is eligible for shared savings payment
- In example below, assume 95% quality score

	model 1	model 2
pre-cap shared savings payment	$110 * 50% * 95% = $52.25	$110 * 60% * 95% = $62.70
compare to cap	$500 * 10% = $50	$500 * 15% = $75
shared savings payment	$50	$62.7

Model II Shared Loss Example For Accountable Community XYZ, Years 2 & 3

- Benchmark TCOC for Year 1: $500 PMPM
- Actual TCOC for Year 1: $570 PMPM
- Loss = $70 PMPM, exceeds 2% threshold, so AC is liable for shared loss payment
- In example below, assume 95% quality score

	year 2	year 3
pre-cap shared loss payment	$70 * [1 - (60% * 95%)] = $30.10	$70 * [1 - (60% * 95%)] = $30.10
compare to cap	$500 * 5% = $25	$500 * 10% = $50
shared loss payment	$25	$30.10

Quality Measures: 14 Core, Choose 3 of 5 Elective

AT-RISK POPULATIONS (30% OF QUALITY SCORE)

1. CORE: Diabetes - Glucose Control (HbA1c Control) (adults). CORE: Diabetes- Eye Care. Percentage of Members 18-75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam performed within past 1-2 years.
2. CORE: Asthma- Medication Management Percentage of Members ages 5-64 who were identified as having persistent asthma and were appropriately prescribed controller medication.
3. ELECTIVE: Diabetes (HbA1c Testing) (adults). Percentage of Members 18-75 years of age with diabetes (type 1 or type 2) who had a Hemoglobin A1c test in the measurement year .
4. ELECTIVE: Diabetes- Nephropathy. Percentage of Members 18-75 years of age with diabetes with nephropathy screening within previous 12 months.
5. ELECTIVE: Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Pulmonary Disease (COPD). Adults with a new (within the measurement year) diagnosis or newly active COPD who received Spirometry testing to confirm the diagnosis. Spirometry testing must occur 730 days (2 years) prior to or 180 days after the diagnosing event. Age 42 and older.
6. ELECTIVE: Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Pulmonary Disease (COPD). Adults with a new (within the measurement year) diagnosis or newly active COPD who received Spirometry testing to confirm the diagnosis. Spirometry testing must occur 730 days (2 years) prior to or 180 days after the diagnosing event. Age 42 and older.
7. ELECTIVE: Follow-Up After Hospitalization for Mental Illness. Percentage of discharges for Members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.
8. ELECTIVE: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. Percentage of adolescents and adults Members with a new episode of alcohol or other drug (AOD) dependence who received the following: Initiation of AOD treatment. Engagement of AOD treatment.

Quality Measures

CARE COORDINATION/ PATIENT SAFETY (30%)

1. CORE: Prevention Quality Indicator (PQI #92). Prevention Quality Indicator (PQI) composite of chronic conditions per 100,000 population, ages 18 years and older.
2. CORE: Pediatric Quality Chronic Composite (PDI #92) Pediatric Quality Indicators of chronic conditions per 100,000, ages 6-17.
3. CORE: Non-emergent ED Use. Maine ED study developed list of 14 diagnoses identified as preventable. The criteria for selection of the included conditions were: 1) matching diagnostic codes of conditions seen frequently both in hospital emergency departments and in primary care settings; 2) eliminating any diagnoses that, when seen in an emergency department, result in the patient being admitted more than 5 percent of the time; 3) a review of the list of diagnoses generated through this process by clinicians with emergency department experience and selection by the clinicians of a sub-set of conditions
4. CORE: Percent of Primary Care Providers who Successfully Qualify for a Health Information Technology EHR Program Incentive Payment.
5. CORE: Plan- All Cause Readmission. For Members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days
6. ELECTIVE: Use of High-Risk Medications in the Elderly The percentage of Members 66 years of age and older who received at least one high-risk medication

Quality Measures

PATIENT EXPERIENCE (10%)

1. CORE: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician & Group Surveys Version: 12-Month Survey with Patient-Centered Medical Home (PCMH) Items (child and/or adult version as appropriate)

PREVENTIVE HEALTH (30%)

1. CORE: Adolescent Well-Care Visit (12-21). Percentage of Members who were 12-21 years of age and who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.
2. CORE: Developmental Screening - First Three Years of Life
3. CORE: Well-Child Visits ages 0-15 months percent of children with 6 or more well child care visits in the first 15 months
4. CORE: Well-Child Visits ages 3-6 percent of children 3-6 years old with at least one well child visit per year
5. CORE: Well Child Visits ages 7-11: percent of children 7-11 years old with at least one well child visit per year.
6. ELECTIVE: Breast Cancer Screening Measure: Percentage of female Members 50-74 year of age who had a mammogram to screen for breast cancer.

Quality Measures

AC Performance Level	Quality Points per Measure	EHR Meaningful Use Points per Measure
90+ percentile or percent	2 points	4 points
70+ percentile or percent	1.7 points	3.4 points
50+ percentile or percent	1.4 points	2.8 points
30+ percentile or percent	1.1 points	2.1 points
<30 percentile or percent	No points	No points

Data Feedback to Providers

Reports to Accountable Community providers will include the following:

- Utilization report (monthly)
- Attributed member roster (quarterly)
- Actual TCOC (quarterly) broken out by practice and service category
- Performance on quality measures (quarterly), including list of which members are in numerator and denominator of each measure

(All reports use most recent 12 months of data at the time the report is generated)

The AC Portal & Monthly Utilization Reports

Portal will have two functionalities, both aimed at helping identify members for intervention:

1. **Utilization Dashboard.** Shows data for each member in the most recent quarterly attribution roster (these metrics are identical to those used in the Health Home portal):

    1. # of Hospitalizations in the last quarter
    2. # of Hospitalizations in the last year
    3. # of ED visits in the last quarter
    4. # of ED visits in the last year
    5. Paid claims greater than $10,000
    6. 11 or more meds (# of meds)
    7. No PCP visit in the last year
    8. No HbA1c test in the last qtr (Diab)
    9. No LDL panel in the last year (Diab)
    10. No LDL panel in the last year (CVD)

The AC Portal & Monthly Utilization Reports

1. **Utilization Dashboard, cont'd**
   - Utilization data is based on the most current 12 months of data available.
   - For each member, there are also fields indicating:
     - The member's prospective risk score
     - The basis for the member's attribution to the AC (i.e., Health Home, claims, or ED use)
     - If the member was eligible for MaineCare that month
   - Pending the Portal's functionality, MaineCare has been sending monthly to ACs in Excel format.

2. **Claims Download.** For drill down, ACs and practices can download all claims in last twelve months for any attributed members.

Quarterly TCOC Report

- To give ACs:
  a) a sense of how their actual TCOC is changing from quarter-to-quarter, and
  b) a granular look at how their TCOC breaks out,

  these reports show TCOC during the most recent 12 months (using the most recent quarterly attribution roster)
- Data is provided at the AC-level and practice-level and is broken out by:
  1. Population category (Children, Duals, Aged Blind or Disabled non-duals, Adults)
  2. Service category

Quarterly TCOC Report, cont'd

- At the AC-level and the practice level, for each of the 12 categories, the report provides the five providers with the highest spend for the time period covered by the report (so that the AC can outreach to those providers if desired), with metrics for each of those providers.

Service Category	Gross Payment Amounts After Adjustments	Members Receiving This Service	Units	Annual Utilization per 1000 Members	Average Unit Cost	PMPM After Adjustments
General Acute Inpatient	$ 735,047	95	110	144.15	$ 6,682.25	$ 80.27
provider w highest spend	$ 420,119	67	81	106.15	$ 5,186.66	$ 45.88
provider w 2nd highest spend	$ 242,035	17	17	22.28	$ 14,237.34	$ 26.43
etc	$ 18,926	3	4	5.24	$ 4,731.43	$ 2.07
etc	$ 16,659	2	2	2.62	$ 8,329.32	$ 1.82
etc	$ 15,017	1	1	1.31	$ 15,016.60	$ 1.64
Psychiatric Inpatient	$ 3,535	1	1	1.31	$ 3,534.65	$ 0.39
provider w highest spend	$ 3,535	1	1	1.31	$ 3,534.65	$ 0.39
provider w 2nd highest spend	$ -	-	-	-	$ -	$ -
etc	$ -	-	-	-	$ -	$ -
etc	$ -	-	-	-	$ -	$ -
etc	$ -	-	-	-	$ -	$ -
General Acute Outpatient	$ 800,635	870	5,590	7,325.54	$ 143.23	$ 87.43
provider w highest spend	$ 637,238	693	5,214	6,832.81	$ 122.22	$ 69.59
provider w 2nd highest spend	$ 26,636	27	65	85.18	$ 409.79	$ 2.91
etc	$ 26,054	4	19	24.90	$ 1,371.25	$ 2.85
etc	$ 20,414	18	50	65.52	$ 408.28	$ 2.23
etc	$ 13,633	14	48	62.90	$ 284.02	$ 1.49

Quarterly Quality Report

- Shows each attributed member and whether they are included in the numerator and denominator for each measure.
- Shows the AC's score on each measure if the score were to be calculated at that time, as well as the score at each practice.